EMPLOYEE INJURY REPORT FORM

Use this form to report accidents, injuries, and/or first aid treatment. This report should be completed **in full** and returned to the school nurse within 24 hours of the event.

TO BE COMPLETED BY EMPLOYEE – DO NOT LEAVE BLANKS

Date of Injury:_____ **Date of Hire:** _____

1. PERSON INVOLVED

Full Name: _____ **Address:** _____

Identification: Social Security No._____ **Date of Birth**_____ **Gender** _____

Phone: _____ **E-Mail:** _____

Occupation: _____

2. THE INCIDENT

Date of Incident: _____ **Time:** _____ ☐ AM ☐ PM

Location: _____

Describe the Incident: _____

_____

3. INJURIES

Was anyone injured? ☐ Yes ☐ No **Recurrence of previous injury?** ☐ Yes ☐ No

If yes, nature of injuries: (laceration, burn, fracture, sprain, etc.) _____

_____

If yes, part of body: (left arm, right foot, multiple, etc.) _____

_____

If yes, cause of injuries: (student altercation, lifting, fall, etc.) _____

_____

4. WITNESSES

Were there witnesses to the incident? ☐ Yes ☐ No
If yes, enter the witnesses' names and phone #: _____

TO BE COMPLETED BY SCHOOL NURSE

5. MEDICAL TREATMENT

Was medical treatment provided? ☐ Yes ☐ No ☐ Refused

If yes, where was medical treatment provided? ☐ On site ☐ Walk In ☐ Hospital

☐ Emergency Dept
☐ Hospitalization >24 hours
☐ Future Major Medical/Lost Time anticipated
☐ Death due to Injury

6. WORK STATUS

Is employee missing time from work: ☐ Yes ☐ No (not doctor appointments)

If Yes, how much time has employee missed? _____

Initial Date Last Day Worked_____

Initial Date Disability Began _____

Initial Return to Work Date _____

Restrictions ☐ Yes ☐ No If yes, describe_____

7. SCHOOL PERSONNEL RECEIVING REPORT

Signature: _____ **Date:** _____

Print Name: _____

SUPERVISOR USE ONLY

Report received by: _____ **Date:** _____

Follow-up action taken: _____

Action Taken: _____

_____

FORWARD IMMEDIATELY UPON COMPLETION TO BUSINESS OFFICE